

433.417: Home Visits: Service Limitations

Payment for a visit by a physician to a recipient's home is limited to one visit per recipient per day. (For information on additional home health services reimbursable under the Medical Assistance Program, see 130 CMR 433.478.)

433.418: Consultations: Service Limitations

Only one comprehensive consultation per recipient per case episode is reimbursable. Additional consultation visits per episode must be billed as follow-up consultations.

NON-TEXT PAGE

433.419: Certified Nurse-Midwife Services

(A) (Reserved)

(B) Reimbursable and Nonreimbursable Services.

(1) Certified nurse-midwife services concerning the care of women throughout the course of pregnancy, labor, and delivery periods, and care to mothers and their infants in the post-partum period, as well as gynecological and family planning services are reimbursable under the following conditions.

(a) The services must be limited to the scope of practice authorized by state law or regulation pertaining to certified nurse-midwives.

(b) The nurse-midwife must meet the educational and certification requirements mandated by state law or regulation.

(c) The nurse-midwife must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.

(2) Reimbursement is available for intrapartum services immediately prior to delivery to recipients who are experiencing unanticipated medical complications that result in cesarean sections or complicated vaginal deliveries that require the services of a physician. This service is not reimbursable when the nurse-midwife bills for the delivery, whether on a fee-for-service or global fee basis.

(3) Childbirth education classes are not reimbursable.

(4) Only those surgical services specified in the Nurse-Midwife Services section in Subchapter 6 of the *Physician Manual* are reimbursable.

(C) Requirements for Participation.

(1) The nurse-midwife must meet the educational and certification requirements mandated by state law or regulation.

(2) The nurse-midwife must enter into a formal collaborative arrangement with a physician or group of physicians, as required by state law or regulation, for referral and consultation in the event of medical complications. The collaborating physician must be a Medical Assistance provider and must engage in the same type of clinical practice as the nurse-midwife.

(3) If the graduate nurse-midwife misses a scheduled national certification examination or fails to pass the examination, the graduate nurse-midwife must immediately cease providing services to recipients, in accordance with state regulations.

(4) After the nurse-midwife passes the scheduled certification examination, the nurse-midwife must obtain authorization to practice in an expanded role from the Board of Registration in Nursing.

(5) If the nurse-midwife's license or authorization to practice in an expanded role as a certified nurse-midwife expires or is suspended, the nurse-midwife must immediately cease providing services to recipients.

(D) Salaried Nurse-Midwives.

(1) When a nurse-midwife is a salaried employee of a physician or group practice, such employment shall satisfy the requirement for a collaborative arrangement.

(a) The employer must ensure that the nurse-midwife complies with the requirements in 130 CMR 433.419(C).

(b) Only the employer may submit claims for the services provided by the nurse-midwife. (This is an exception to 130 CMR 450.301.)

(i) Such claims are submitted using only the service codes appropriate to nurse-midwife services, in accordance with Subchapter 6 of the *Physician Manual*.

(ii) Only one claim for each service may be submitted. (Consultation between a salaried nurse-midwife and a salaried nurse-midwife's employer does not constitute a service.)

(2) Services provided by a nurse-midwife who is a salaried employee of a hospital or other facility are not reimbursable as discrete fee-for-service items; such services are reimbursable only as components of the hospital's or facility's Medical Assistance rate.

(3) A salaried nurse-midwife may not participate in the Medical Assistance Program as an independent practitioner.

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(E) Nonsalaried Nurse-Midwives.

(1) In addition to meeting the requirements of 130 CMR 433.419(C), a nonsalaried nurse-midwife must submit to the Division a copy of the license issued by the Board of Registration in Nursing showing authorization to practice as a nurse in an expanded role as a certified nurse-midwife, and must notify the Division in writing within two weeks of a failure to take or pass the national certification examination or of the expiration or suspension of the license or authorization to practice in an expanded role as a nurse-midwife.

(2) To be eligible for payment by the Division, a nonsalaried nurse-midwife must have a Medical Assistance provider number. The application for a provider number must include the name and the provider number of all collaborating physicians. Whenever the nurse-midwife enters into a collaborative arrangement with a physician other than those indicated on the application or changes the address shown on the application, the Division must be notified in writing within two weeks after the change. Notification of a new collaborative arrangement must include the signatures of both the nurse-midwife and the new collaborating physician.

433.420: Obstetric Services: Introduction

The Department offers two methods of reimbursement for obstetric services: the fee-for-service method and the global fee method. Fee for service requires submission of claims for services as they are performed and is always available to a provider for all reimbursable obstetric services. The global fee is available only when the conditions specified in 130 CMR 433.421 are met. Global fee offers two options: the standard global fee and the enhanced global fee.

433.421: Obstetric Services: Global Fee Method of Reimbursement

(A) Definition of Global Fee. The global fee is a single inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The two global fee options (standard global fee and enhanced global fee) are available only when the conditions in 130 CMR 433.421 are met. The two options are fully defined in 130 CMR 433.422 and 433.423.

(B) Eligible Recipients. The Division will pay a standard global fee or enhanced global fee for obstetric services provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(C) Conditions for Global Fee.

(1) A physician or independent nurse-midwife who assumes responsibility for performing or coordinating a minimum of six prenatal visits, the delivery, and postpartum care for the recipient is the primary provider. In a group practice or when a back-up physician is involved, the primary provider is not required to perform all the components of a global delivery directly. Another member of the practice or a back-up physician can perform services; he or she is a referred provider. Only providers in the same group practice or back-up physicians are considered referred providers. These referred services must not be billed for separately; they will be reimbursed as part of the global fee.

(2) Only the primary provider may claim payment of the global fee. A physician who is a primary provider may claim payment of the global fee for the obstetric services provided by a nurse, nurse practitioner, nurse-midwife, or physician assistant in his or her employ. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).) All global fee claims must use the delivery date as the date of service.

(3) All of the components of a global fee must be provided at a level of quality consistent with the standards of practice of the American College of Obstetrics and Gynecology.

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(D) Multiple Providers. When more than one provider is involved in prenatal, delivery, and postpartum services for the same recipient, the following conditions apply.

(1) The global fee may be claimed only by the primary provider and only if the required services (minimum of six prenatal visits, a delivery, and postpartum care) are provided directly by the primary provider, by a nurse, nurse practitioner, nurse-midwife, or physician assistant in his employ, or by a referred provider, that is, a member of the same group practice or a back-up physician. (This constitutes an exception to 130 CMR 450.301(A) and 130 CMR 433.451(A).)

(2) If the primary provider bills for the global fee, no referred provider may claim payment from the Division. Payment of the global fee constitutes payment in full both to the primary provider and each referred provider.

(3) If the primary provider bills for the global fee, any provider who is not a referred provider but who performed prenatal visits or postpartum visits for the recipient may claim payment for such services only on a fee-for-service basis. If the primary provider bills for the global fee, no other provider may claim payment for the delivery.

(4) If the primary provider bills on a fee-for-service basis, any other provider may claim payment on a fee-for-service basis for prenatal, delivery, and postpartum services provided to the same recipient.

(E) Recordkeeping for Global Fee. The primary provider is responsible for documenting, in accordance with 130 CMR 433.409, all the service components of a standard or enhanced global fee; this includes services performed by referred providers or employees of the primary provider. All hospital and ambulatory services, including risk assessment and medical visits, must be clearly documented in each global fee recipient's record in a way that allows for easy review of her obstetrical history.

433.422: Obstetric Services: Standard Global Fee

The standard global fee is an all-inclusive fee for all prenatal visits, the delivery, and one postpartum visit. The physician or independent nurse-midwife must perform or coordinate a minimum of six prenatal visits, the delivery, and postpartum care to claim the standard global fee.

(A) For a physician, the global fee includes payment for the delivery (Caesarean or pelvic), all prenatal visits, and one postpartum visit.

(B) For an independent nurse-midwife, the global fee includes payment for the delivery (pelvic only), all prenatal visits, and one postpartum visit.

433.423: Obstetric Services: Enhanced Global Fee

The enhanced global fee includes all the components of the standard global fee (a minimum of six prenatal visits, the delivery, and postpartum care), and requires three additional categories of service as a condition for payment. These three categories are coordinated medical management; health-care counseling; and obstetrical-risk assessment and monitoring. The primary provider must develop a plan of care, documented in the recipient's medical record, for each enhanced global delivery recipient; the plan of care must include services in each category that are relevant to the recipient's condition.

(A) Coordinated Medical Management. The physician and nurse, nurse practitioner, nurse-midwife, or physician assistant employed by the physician, or an independent nurse-midwife must provide referral to and coordination of the medical and support services necessary for a healthy pregnancy and delivery. This includes the following:

- (1) tracking and follow-up of the patient's activity to ensure completion of the patient care plan, with the appropriate number of visits;
- (2) coordination of medical management with necessary referral to other medical specialties and dental services; and
- (3) referral to WIC (the Special Supplemental Food Program for Women, Infants, and Children), counseling, and social work as needed.

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(B) Health-Care Counseling. In conjunction with providing prenatal care, the physician and nurse, nurse practitioner, physician assistant, or nurse-midwife employed by the physician, or the independent nurse-midwife will be required to provide health-care counseling to the woman over the course of the pregnancy. Topics covered must include, but are not limited to, the following:

- (1) PGH screening for teenage pregnant women;
- (2) smoking and substance abuse;
- (3) hygiene and nutrition during pregnancy;
- (4) care of breasts and plans for infant feeding;
- (5) obstetrical anesthesia and analgesia;
- (6) the physiology of labor and the delivery process, including detection of signs of early labor;
- (7) plans for transportation to the hospital;
- (8) plans for assistance in the home during the postpartum period;
- (9) plans for pediatric care for the infant; and
- (10) family planning.

(C) Obstetrical-Risk Assessment and Monitoring. The physician and nurse, nurse practitioner, physician assistant, or nurse-midwife employed by the physician, or the independent nurse-midwife must manage the recipient's obstetrical-risk assessment and monitoring. Medical management requires monitoring the woman's care and coordinating diagnostic evaluations and services as appropriate. The professional and technical components of these services will be reimbursed separately and should be billed for on a fee-for-service basis. Such services may include, but are not limited to, the following:

- (1) counseling specific to high-risk patients (for example, antepartum genetic counseling);
- (2) evaluation and testing (for example, amniocentesis); and
- (3) specialized care (for example, treatment of premature labor).

433.424: Obstetric Services: Fee-for-Service Method of Reimbursement

The fee-for-service method of reimbursement is always available to a provider for obstetric services reimbursable under the Medical Assistance Program. If the global fee requirements in 130 CMR 433.421 are not met, the provider or providers may claim payment from the Division only on a fee-for-service basis, as specified below.

(A) When there is no primary provider for the obstetric services performed for the recipient, each provider may claim payment only on a fee-for-service basis.

(B) If the pregnancy is terminated by an event other than a delivery, each provider involved in performing obstetric services for the recipient may claim payment only on a fee-for-service basis.

(C) When an independent nurse-midwife is the primary provider and a Caesarean section is performed by the collaborating physician, the independent nurse-midwife may claim payment for the prenatal visits only on a fee-for-service basis, using the service codes and descriptions in Subchapter 6 of the *Physician Manual*. The collaborating physician may claim payment for the Caesarean section only on a fee-for-service basis.

(D) When additional services (for example, ultrasound or special tests) are performed, the provider may claim payment for these only on a fee-for-service basis.

433.425: Ophthalmology Services: Service Limitations

The comprehensive and routine follow-up eye examinations in Subchapter 6 of the *Physician Manual* are reimbursable, subject to the following limitations.

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(A) Prior authorization from the Division is required for a comprehensive eye examination (Service Code 9300) if the service has been furnished:

- (1) within the preceding 12 months, for a recipient under 21 years of age; or
- (2) within the preceding 24 months, for a recipient 21 years of age or older.

(B) The services designated "I.P." in the ophthalmology service descriptions in Subchapter 6 of the *Physician Manual* are reimbursable only if performed independently of a comprehensive eye examination (Service Code 9300).

(C) Titmus vision test (Service Code 9347) or a similar screening device is reimbursable only once per year per recipient.

(D) Eyeglasses and other ophthalmic materials, with the exception of over-the-counter items such as magnifiers, may be dispensed only upon prescription, even if the prescriber dispensed the materials himself. The prescription must be based upon the results of a vision examination performed by the prescriber. The prescription must include all information that is necessary to enable a dispensing practitioner to fill the prescription. The prescriber must provide the recipient with a signed copy of the prescription without extra charge. The date or dates upon which the prescription is filled or refilled must be recorded on the recipient's copy of the prescription. (For further regulations concerning ophthalmic materials, see 130 CMR 402.000s.)

433.426: Audiology Services: Service Limitations

(A) Audiology services are reimbursable only when provided by a physician or by an audiologist certified by the American Speech and Hearing Association and employed by a physician. This limitation does not apply to an audiometric hearing test, pure-tone, air only (Service Code 9350).

(B) Only physicians who have been approved by and received written authorization from the Division to perform hearing aid evaluations (Service Code 9367) will be paid for such services.

(C) The Division will pay for hearing aids only when the hearing aid evaluation is performed by an approved provider and only if prior authorization has been obtained.

433.427: Allergy Testing: Service Limitations

(A) The service codes and descriptions in Subchapter 6 of the *Physician Manual* apply to allergy testing performed by a physician or under a physician's direct supervision. All fees include payment for physician observation and interpretation of the tests in relation to the recipient's history and physical examination. A physician may bill for an initial consultation (see Service Codes 9152 and 9153 in Subchapter 6 of the *Physician Manual*) in addition to allergy testing.

(B) Blood tests and pulmonary function tests (such as spirometry and expirogram) used only for diagnosis and periodic evaluation may not be claimed more than three times annually per recipient.

(C) Immunotherapy and desensitization (extracts) are reimbursable up to \$84.00 annually per recipient (see Service Code 9800 in Subchapter 6 of the *Physician Manual*). The amount and anticipated duration of the supply must be listed on the claim form.

(D) Follow-up office visits for injections and re-evaluation are reimbursable as office visits (see Subchapter 6 of the *Physician Manual*).

(E) All sensitivity tests listed in Subchapter 6 of the *Physician Manual* are for one recipient during one year regardless of the type of tests performed or the number of visits required.

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433.428: Psychiatry Services: Introduction

(A) Eligible Recipients. The Division pays for the psychiatric services described in 130 CMR 433.429 when provided to Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111. (For other reimbursable mental health services see 130 CMR 433.472.)

(B) Reimbursable Services. The Division pays for the psychiatry services described in 130 CMR 433.429.

(C) Nonreimbursable Services.

(1) Nonphysician Services. The Division will not pay a physician for services provided by a social worker, psychologist, or other nonphysician mental health professional employed or supervised by the physician.

(2) Research and Experimental Treatment. The Division will not pay a physician for research or experimental treatment. This includes, but is not limited to, any method not generally accepted or widely used in the field, or any session conducted for research rather than for a recipient's clinical need.

(3) Nonmedical Services. The Division will not pay a physician for nonmedical services, including, but not limited to, the following:

- (a) vocational rehabilitation services;
- (b) educational services;
- (c) recreational services (play therapy, the use of play activities with a child in an identified treatment setting as an alternative to strictly verbal expression of conflicts and feelings, is not considered a recreational service and is reimbursable);
- (d) street worker services (information, referral, and advocacy to certain age populations; liaison with other agencies; role modeling; and community organization);
- (e) life-enrichment services (ego-enhancing services such as workshops or educational courses provided to functioning persons); and
- (f) biofeedback.

(4) Nonmedical Programs. The Division will not pay for diagnostic and treatment services that are provided as an integral part of a planned and comprehensive program that is organized to provide primarily nonmedical or other nonreimbursable services. Such programs include freestanding alcohol or drug detoxification programs, freestanding methadone maintenance programs, residential programs, day activity programs, drop-in centers, and educational programs.

(5) Psychological Testing. The Division will not pay for psychological testing provided by a physician.

(D) Recordkeeping (Medical Records) Requirements. Psychiatric medical records must be in compliance with the Division's general recordkeeping requirements (see 130 CMR 433.409). In addition, the following specific information must be included in the medical record for each recipient receiving psychiatric services:

- (1) the condition or reason for which psychiatric services are provided;
- (2) the recipient's diagnosis;
- (3) the recipient's medical history;
- (4) the recipient's social and occupational history;
- (5) the treatment plan;
- (6) the physician's short- and long-range goals for the recipient;
- (7) the recipient's response to treatment; and
- (8) if applicable, a copy of the signed consent for electroconvulsive therapy.

(E) Frequency of Treatment. The Division will pay a physician for only one session of each type of service provided to a recipient in one week except for crisis intervention, as discussed below.

(1) In a crisis, as defined in 130 CMR 433.429(K), the Division will pay a physician for extra sessions. The physician must bill for these services using the service code for crisis intervention and must document the following in the recipient's record:

- (a) the recipient is in a state of marked life change or crisis;
- (b) the recipient's ability to function is likely to deteriorate; and

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(c) the plan of treatment is to resume or to initiate regular weekly sessions after the resolution of the crisis.

(2) Although prior authorization is still required after 17 treatment sessions, the Division will pay a physician for more than one type of service provided to a recipient in one week if the additional service or services are medically necessary. The recipient's record must document the circumstances necessitating the provision of more than one type of service. The record must make clear that the substitution of one type of service for another would not adequately benefit the recipient and that an additional type of service is necessary.

433.429: Psychiatry Services: Scope of Services

130 CMR 433.429 describes the services that a psychiatrist may provide, including the limitations imposed on those services by the Division. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the recipient; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The Division will pay a physician for individual psychotherapy provided to a recipient only when the physician himself treats the recipient. This service includes diagnostics.

(B) Family and Couple Therapy. The Division pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one hour per session per week, regardless of the number of family members present or the presence of a cotherapist.

(C) Group Therapy. The Division pays for therapy provided to a group of persons, most of whom are not related by blood, marriage, or legal guardianship. The Division will pay for group therapy only if the session lasts for at least 90 minutes with the physician. Payment is limited to one fee per group member with a maximum of ten members per group regardless of the presence of a cotherapist.

(D) Diagnostic Services. The Division pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(E) Reevaluation. Without prior authorization, the Division pays for the reevaluation of a recipient who has been out of treatment for at least six months and who has used up his lifetime benefit of 17 treatment sessions. A provider may bill for a maximum of two one-hour units per recipient per calendar year for the purpose of designing a treatment plan and requesting prior authorization for a particular number of sessions.

(F) Long-Term Therapy. The Division defines long-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to extend more than 17 sessions.

(G) Short-Term Therapy. The Division defines short-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to terminate within 17 sessions.

(H) Medication Review. The Division will pay for a recipient visit to the physician specifically for the prescription, review, and monitoring of medication. If this service is not combined with psychotherapy, it must be billed as a minimal office visit (Service Code 9001 or 9031). The Division will not pay separately for medication review if it is performed on the same day as another service.

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(I) Case Consultation. The Division will pay for a consultation with another agency or person when the physician has accepted a patient for treatment and continues to assume primary responsibility for the patient's treatment, while the other agency continues to provide ancillary services.

(J) Family Consultation. The Division will pay for a preplanned meeting of at least one-half hour with the parent or parents or legal guardian of a child who is being treated by the physician, when the parent or parents or legal guardian are not clients of the physician.

(K) Crisis Intervention/Emergency Services. The Division will pay for an immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to recipients showing sudden, incapacitating emotional stress. The Division will pay only for face-to-face contact; telephone contacts are not reimbursable. The Division will pay for no more than two hours of emergency services per recipient on a single date of service.

(L) Electroconvulsive Therapy. The Division will pay for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(M) After-Hours Telephone Service. The physician must provide telephone coverage during the hours when the physician is unavailable, for recipients who are in a crisis state.

(N) Hospital Inpatient Visit. A visit to a hospitalized recipient is reimbursable only as a hospital visit (see 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided, in which case the service codes in Subchapter 6 of the *Physician Manual* may be used. Payment will be made for only one visit per recipient per day.

(O) Routine Inpatient Care. The Division will pay for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from the Division or its agent in accordance with 130 CMR 433.415(A). Routine inpatient care includes the following services. The amounts of services listed are the maximum reimbursable; fewer services may be provided.

- (1) During the first week of hospitalization, the Division will pay for the following:
  - (a) for an initial evaluation:
    1. up to three hours for a recipient under 19 years of age; and
    2. up to two hours for a recipient aged 19 or older;
  - (b) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
    1. up to five hours for a recipient under 19 years of age; and
    2. up to three hours for a recipient aged 19 or older; and
  - (c) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:
    1. up to one day for a recipient under 19 years of age; and
    2. up to three days for a recipient aged 19 or older.
- (2) During each of the second and third weeks of hospitalization, the Division will pay a psychiatrist for the following:
  - (a) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
    1. up to five hours for a recipient under 19 years of age; and
    2. up to three hours for a recipient aged 19 or older; and
  - (b) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:
    1. up to two days for a recipient under 19 years of age; and
    2. up to four days for a recipient aged 19 years or older.

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- (3) The Division will pay for only one type of service a day.
- (4) In order to be reimbursable, individual psychotherapy, regulation of medication, and daily medical care must involve face-to-face contact between the psychiatrist and the recipient.
- (5) For extended hospitalization, if the hospital has complied with the Division's concurrent review process, the Division will pay a psychiatrist for the services described in 130 CMR 433.429(O)(2), that is, for the same amount of services reimbursable in the second and third weeks.

433.430: Dialysis: Service Limitations

- (A) Medicare Coverage. Effective July 1973, Medicare was expanded to become the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Recipients being treated for chronic renal disease must be referred to their Welfare Service Office or Social Security Administration office to determine Medicare eligibility.
- (B) Service Limitations. Service Codes 9260, 9262, and 9264 apply only to hospitalized recipients who are:
  - (1) being dialyzed for acute renal failure;
  - (2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or
  - (3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

- (A) The services listed in 130 CMR 433.431 are reimbursable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician.
- (B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are reimbursable under the Medical Assistance Program upon referral by a physician (see 130 CMR 433.471).

433.432: Other Medical Procedures

- (A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed for in addition to an office visit.
- (B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure. (For consultation services, see Subchapter 6 of the *Physician Manual*.)
- (C) Pulmonary Procedures. Fees for the procedures listed in Subchapter 6 of the *Physician Manual* include payment for laboratory procedures, interpretations, and physician's services. These services may be billed for in addition to an office visit.
- (D) Dermatological Special Procedures. These services may be billed for in addition to an office visit.
- (E) Unlisted Procedures. Service Code 9299 should be used only if there is no "Not otherwise classified" code in the appropriate section.

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433.433: Nurse Practitioner Services

130 CMR 433.433 applies specifically to nurse practitioners. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse practitioners, such as service limitations, recordkeeping, report, and prior authorization requirements.

(A) (Reserved)

(B) Reimbursable Services. The nurse practitioner services listed in Subchapter 6 of the *Physician Manual* are reimbursable under the following conditions.

- (1) The services must be limited to the scope of practice authorized by state law or regulation (244 CMR 4.00).
- (2) The nurse practitioner must meet the educational and certification requirements mandated by state law or regulation.
- (3) The nurse practitioner must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.

(C) Education and Certification Requirements. In order to participate in the Medical Assistance Program, a nurse practitioner must have successfully completed a formal educational program for nurse practitioners as required by the Massachusetts Board of Registration in Nursing.

- (1) A nurse practitioner who has completed such educational requirements may provide services to recipients prior to the first certification examination for which the nurse practitioner is eligible.
- (2) If the scheduled examination is missed, the nurse practitioner must immediately cease providing services to recipients.
- (3) Upon receiving notice of failure to pass the examination, the nurse practitioner must immediately cease providing services to recipients.
- (4) After passing the examination, the nurse practitioner must obtain authorization to practice from the Board of Registration in Nursing.
- (5) When such authorization expires or is suspended, the nurse practitioner must immediately cease providing services to recipients.

(D) Collaborative Arrangement. To participate in the Medical Assistance Program, a nurse practitioner must enter into a formal collaborative arrangement with a physician or group of physicians for referral and consultation in the event of medical complications. The collaborating physician must be a Medical Assistance provider. The nurse practitioner must practice in accordance with written guidelines developed in conjunction with the physician in accordance with 244 CMR 4.22. The guidelines must specify:

- (1) what services the nurse practitioner can perform; and
- (2) the established procedures for common medical problems.

(E) Salaried Nurse Practitioners. When a nurse practitioner is a salaried employee of a physician or group practice, such employment shall satisfy the requirement for a collaborative arrangement.

- (1) The employer must ensure that the nurse practitioner complies with the requirements in 130 CMR 433.433(C).
- (2) The employer must submit claims for the services provided by the nurse practitioner. (This is an exception to 130 CMR 450.301.) Only one claim for each service may be submitted, even if a consultation is required.

(F) Independent (Nonsalaried) Nurse Practitioners.

- (1) In addition to meeting the requirements of 130 CMR 433.433(C), an independent nurse practitioner must submit to the Division copies of the license issued by the Massachusetts Board of Registration in Nursing showing authorization to practice as a nurse in an expanded role, the certification by a nationally recognized accrediting body approved by the Board for nurse practitioners, and all collaborative arrangements. A nurse practitioner must notify the Division in writing within two weeks of a failure to take or pass the certification examination or of the expiration or suspension of such certification.

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(2) To be eligible for payment by the Division, an independent nurse practitioner must have a Medical Assistance provider number. The application for a provider number must include the name and Medicaid provider number of all collaborating physicians. Whenever the nurse practitioner enters into a collaborative arrangement with a physician other than the one indicated on the application or changes the address shown on the application, the Division must be notified in writing within two weeks after the change. Notification of a new collaborative arrangement must include the signatures of both the nurse practitioner and the new collaborating physician, as well as the new physician's Medicaid provider number.

433.436: Radiology Services: Introduction

The Division will pay for the radiology services in Subchapter 6 of the *Physician Manual* only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Eligible Recipients. The Division pays for the radiology services in Subchapter 6 of the *Physician Manual* when provided to Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(B) Provider Eligibility. A provider of portable X-ray services is eligible to participate in the Medical Assistance Program only if the provider is certified by Medicare.

(C) Request for Portable X-Ray Services. Portable X-ray services may be provided to a recipient at a mobile site (see 130 CMR 433.407(A)) at the written request of a licensed physician. This written request must specify the reason the X ray is required, the area of the body to be exposed, the number of radiographs to be obtained, the views needed, and a statement of the recipient's condition that necessitates portable X-ray services. If the recipient resides in a long-term care facility, a copy of this written request must be kept in the recipient's medical record in the facility as well as in the recipient's record maintained by the physician.

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (see 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X-rays must be labeled adequately with the following:

- (1) the recipient's name;
- (2) the date of the examination;
- (3) the nature of the examination; and
- (4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Portable X-Ray Services. When a physician provides portable X-ray services to a recipient at a mobile site (see 130 CMR 433.407(A)), the Division will pay for the X rays according to the appropriate radiology service codes and descriptions in Subchapter 6 of the *Physician Manual*. The Division will also pay for one visit, but only one visit, regardless of the number of recipients receiving portable X-ray services at that mobile site.

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(B) Computerized Axial Tomography (CT Scans). CT scan services (head and body scans) are reimbursable by the Division only when performed in a facility having a Determination of Need for a CT scanner by the Massachusetts Department of Public Health. The Division will pay a physician directly only for the professional component (interpretation) of a CT scan. All CT scan services must meet current Medicare standards.

(C) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the Division will pay the physician 40% of the maximum allowable fee. The Division will not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the Division will pay a physician for interpreting an X ray that was previously read and taken in a different hospital, according to the appropriate service description in Subchapter 6 of the *Physician Manual*.

(D) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the Division will pay the physician 50% of the maximum allowable fee.

(E) Surgical Introductions and Interpretations. The Division will pay a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

- (1) Only one surgical introduction per operative session is reimbursable at 100% of the maximum allowable fee.
- (2) In a single operative session:
  - (a) no more than three additional surgical introductions using the same puncture site are reimbursable, each at 50% of the maximum allowable fee; and
  - (b) no more than three additional selective vascular studies using the same puncture site are reimbursable, each at the maximum allowable fee.
- (3) Interpretations are reimbursable at 40% of each maximum allowable fee, up to a maximum of three.

(F) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a recipient by one or more physicians are reimbursable only if sufficient documentation for each is shown in the recipient's medical record.

(G) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component will be divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a recipient are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for the clinical laboratory services in Subchapter 6 of the *Physician Manual* when provided to Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.111.

(B) Provider Eligibility. The laboratory service codes and descriptions in Subchapter 6 of the *Physician Manual* apply only to tests performed on a recipient by a physician or by an independent laboratory certified by Medicare.

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(C) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(C)(2), the Division will pay a physician only for laboratory tests performed in his or her office. If a physician uses the services of an independent laboratory, the Division will pay only the laboratory for services provided for a recipient.

(2) A physician may bill the Division for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(D) Information with Specimen. A physician who sends a specimen to an independent laboratory participating in the Medical Assistance Program must also send the following:

- (1) a signed request for the laboratory services to be performed;
- (2) the recipient's Medicaid identification number; and
- (3) the physician's name, address and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The Division will not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the Division will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per recipient specimen, regardless of the number of tests to be performed on that specimen (Service Code 108817).

(B) Professional Component of Laboratory Services. The Division will not pay a physician for the professional component of a clinical laboratory service. The Division will pay a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The Division will not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The fees for laboratory services include payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

- (a) The group of tests is designated as a profile or panel by the physician performing the tests.
- (b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event shall a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

433.440: Drugs: Dispensing

(A) Eligible Recipients.

(1)(a) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for legend drugs as described in 130 CMR 433.440(B).

(b) For Medical Assistance recipients under age 18, the Division pays for nonlegend drugs as described in 130 CMR 433.440(B). For Medical Assistance recipients aged 18 or older, the Division pays only for nonlegend drugs that are certified to be necessary for the life and safety of the recipient. The Division will reimburse for nonlegend drugs as long as the provider's claim has attached to it a written certification on letterhead from the recipient's primary care physician that attests that such drugs are medically necessary for the life and safety of the recipient and that contains a substantiating medical explanation. However, this certification is not required for insulin, which is reimbursable provided there is a prescription for it.